


EXHIBIT


One

Social Security Administration

[Handwritten scribble]

I am going to Kill one
of you mother fucker soon.

JESSIE WALKER


SOCIAL SECURITY
15250 E 12 MILE RD
ROSEVILLE, MI 48066-1837
Date: May 24, 2021
BNC#: 
SVR

Dear JESSIE WALKER

Per your request we completed the reconsideration form over the telephone and I am mailing out the forms SSA-561, 827, and SSA-3441 your signature. Please sign and date the forms that ask for your signature and on the form SSA-3441 put your daughters address where her name is located. You can add any additional information in remarks that you might want us to know. You fax the information to 833-950-2472 attention JPP

If you have any questions, you should call, write, or visit any Social Security office. If you visit an office, please bring this letter. It will help us answer your questions.

Social Security Administration

My Name Is Jessie Walker III
I accuseing the SS Administration, I
stealing my + identity. My life is in danger
I am getting phone calls from people telling
me they found my wallet in Georgia on
A Dead body and send me the picture
By phone I have ~~Reported~~ Reported
this to the social Security Administration.
Nothing was Don. So every pay I sit

WALKER_0095

Parked in ~~front~~ front of the nearest
 SS office hoping some one show up
 so I can grab them. put them in
 my trunk of my car and blow there
 head off. SS is putting my life
 in danger so I am going to kill
 as many SS people that I can
 especially Judges. I Hate you
 People and the moment I lay
 eyes on an SS Rep I am going
 to kill them.

Fuck OFF
 I want too kill all you motherfucker

Form **SSA-561-U2** (06-2019) UF (06-2019)
 Destroy Prior Editions
 Social Security Administration

Page 1 of 4
 OMB No. 0960-0622

REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT: JESSIE WALKER III	CLAIMANT SSN: [REDACTED] 2104	CLAIM NUMBER: (If different than SSN)
ISSUE BEING APPEALED: (Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, etc.) SSI AND SSDI		

I do not agree with the Social Security Administration's (SSA) determination and request reconsideration.
 My reasons are:

Because I am not able to go to work period not right now I don't think I will every be able to work. The information is different than what the medical doctors are talking about

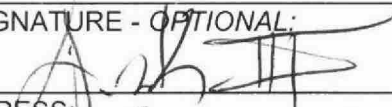
SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) RECONSIDERATION ONLY

THREE WAYS TO APPEAL

I want to appeal your determination about my claim for **SSI** or **SVB**. I have read about the three ways to appeal.
 I have checked the box below:

- ☒ **CASE REVIEW** - You can pick this kind of appeal in all cases. You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.
- ☐ **INFORMAL CONFERENCE** - You can pick this kind of appeal in all SSI cases except for medical issues. In SVB cases, you can pick this kind of appeal only if we are stopping or lowering your SVB payment. You will meet with a person who will decide your case. You can tell that person why you think you are right. You can give us more facts to help prove you are right. You can bring other people to help explain your case.
- ☐ **FORMAL CONFERENCE** - You can pick this kind of appeal only if we are stopping or lowering your SSI or SVB payment. This meeting is like an informal conference, but we can also get people to come in and help prove you are right. We can do this even if they do not want to help you. You can question these people at your meeting.

CONTACT INFORMATION

CLAIMANT SIGNATURE - OPTIONAL: 	NAME OF CLAIMANT'S REPRESENTATIVE: (If any) N-A		
MAILING ADDRESS: [REDACTED]	MAILING ADDRESS: [REDACTED]		
CITY: [REDACTED]	CITY:	STATE:	ZIP CODE:
TELEPHONE NUMBER: (Include area code) [REDACTED] 8888	DATE: 6-3-21	TELEPHONE NUMBER: (Include area code)	DATE:

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE? <input type="checkbox"/> Yes <input type="checkbox"/> No	FIELD OFFICE DEVELOPMENT (GN 03102.300) <input type="checkbox"/> NO FURTHER DEVELOPMENT REQUIRED <input type="checkbox"/> REQUIRED DEVELOPMENT ATTACHED <input type="checkbox"/> REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS
2. IS THIS REQUEST FILED TIMELY? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "NO", attach claimant's explanation for delay. Refer to GN 03101.020)	
SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED: SOCIAL SECURITY 15250 E 12 MILE RD ROSEVILLE MI 48066	SSI CASES ONLY - GOLDBERG KELLY (GK) (SI 02301.310) RECIPIENT APPEALED AN ADVERSE ACTION: <input type="checkbox"/> WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE; <input type="checkbox"/> AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT <input type="checkbox"/> PAYMENT CONTINUATION APPLIES AND INPUT MADE TO SYSTEM

NOTE: Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post and keep a copy for your records.

Claims Folder

WALKER_0097

ADMINISTRATIVE ACTIONS THAT ARE INITIAL DETERMINATIONS (See GN03101.070, GN03101.080, and SI04010.010)

NOTE: These lists cover the vast majority of administrative actions that are initial determinations. However, they are not all inclusive.

Title II

1. Entitlement or continuing entitlement to benefits;
2. Reentitlement to benefits;
3. The amount of benefit;
4. A recomputation of benefit;
5. A reduction in disability benefits because benefits under a worker's compensation law were also received;
6. A deduction from benefits on account of work;
7. A deduction from disability benefits because of claimant's refusal to accept rehabilitation services;
8. Termination of benefits;
9. Penalty deductions imposed because of failure to report certain events;
10. Any overpayment or underpayment of benefits;
11. Whether an overpayment of benefits must be repaid;
12. How an underpayment of benefits due a deceased person will be paid;
13. The establishment or termination of a period of disability;
14. A revision of an earnings record;
15. Whether the payment of benefits will be made, on the claimant's behalf to a representative payee, unless the claimant is under age 18 or legally incompetent;
16. Who will act as the payee if we determine that representative payment will be made;
17. An offset of benefits because the claimant previously received Supplemental Security Income payments for the same period;
18. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that the claimant will not have to return to the disability benefit rolls and thus, whether the claimant's benefits may be continued even though the claimant is not disabled;
19. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a jail, prison, or other correctional institution for conviction of a criminal offense;
20. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a mental health institution or other medical facility because a court found the individual was not guilty for reason of insanity; a court found that he/she was incompetent to stand trial or was unable to stand trial for some other similar mental defect; or, a court found that he/she was sexually dangerous.

Title XVI

1. Eligibility for, or the amount of, Supplemental Security Income benefits;
2. Suspension, reduction, or termination of Supplemental Security Income benefits;
3. Whether an overpayment of benefits must be repaid;
4. Whether payments will be made, on claimant's behalf to a representative payee, unless the claimant is under age 18, legally incompetent, or determined to be a drug addict or alcoholic;
5. Who will act as payee if we determine that representative payment will be made;
6. Imposing penalties for failing to report important information;
7. Drug addiction or alcoholism;
8. Whether claimant is eligible for special SSI cash benefits;
9. Whether claimant is eligible for special SSI eligibility status;
10. Claimant's disability; and
11. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that claimant will not have to return to the disability benefit rolls and thus, whether claimant's benefits may be continued even though he or she is not disabled.

NOTE: Every redetermination which gives an individual the right of further review constitutes an initial determination.

Title VIII (See VB 02501.035)

1. Meeting or failing to meet the qualifying and/or entitlement factors for special veterans benefits (SVB);
2. Reduction, suspension or termination of SVB payments;
3. Applicability of a disqualifying event prior to SVB entitlement;
4. Administrative actions in SVB cases similar to those listed under Title II-items 3, 4, 10, 11 & 16.

Title XVIII

1. Entitlement to hospital insurance benefits and to enrollment for supplementary medical insurance benefits;
2. Disallowance (including denial of application for HIB and denial of application for enrollment for SMIB);
3. Termination of benefits (including termination of entitlement to HI and SMI).
4. Initial determinations regarding Medicare Part B income-related premium subsidy reductions.

Form SSA-827 (03-2020)
Discontinue Prior EditionsPage 1 of 2
OMB No. 0960-0623

Whose Records to be Disclosed

NAME (First, Middle, Last, Suffix)

Jessie Walker III

SSN

2104

Birthday (MM/DD/YYYY)

1968

AUTHORIZATION TO DISCLOSE INFORMATION TO
THE SOCIAL SECURITY ADMINISTRATION (SSA)

** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW **

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes Specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
 - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
 - Drug abuse, alcoholism, or other substance abuse
 - Sickle cell anemia
 - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
 - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed). Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM

The Social Security Administration and to the State agency authorized to process my case (usually called "disability determination services"), including contract copy services, and doctors or other professionals consulted during the process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE

Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am capable of managing benefits ONLY (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure Signature

IF not signed by subject of disclosure, specify basis for authority to sign

☐ Parent of minor ☐ Guardian ☐ Other personal representative
(explain)

(Parent/guardian/personal representative sign here if two signatures required by State law)

Date Signed

Street Address

Phone Number (with area code)

City

State

ZIP

WITNESS

I know the person signing this form or am satisfied of this person's identity:

Sign

IF needed, second witness sign here (e.g., if signed with "X" above)

Phone

Phone Number (or Address)

This general authorization complies with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

WALKER_0099

**Explanation of Form SSA-827,
"Authorization to Disclose Information to the Social Security Administration (SSA)"**

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

**Privacy Act Statement
Collection and Use of Personal Information**

Sections 205(a), 223(d), and 1631(d) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on your claim that could result in a denial or loss of benefits.

We will use the information you provide to determine your eligibility or continuing eligibility for benefits, and your ability to manage any benefits that you currently receive.

We may also share your information for the following purposes, called routine uses:

1. To State audit agencies for auditing State supplementation payments and Medicaid eligibility considerations;
2. To third party contacts where necessary to establish or verify information provided by representative payees or payee applicants; and
3. To Federal, State or local agencies for administering cash or non-cash income maintenance or health maintenance programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0089, entitled Claims Folders Systems; 60-0090, entitled Master Beneficiary Record; 60-0320, entitled Electronic Disability; and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions.

SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

Form **SSA-3441-BK** (01-2021) UF
 Discontinue Prior Editions
 Social Security Administration

Page 3 of 10
 OMB No. 0960-0144

DISABILITY REPORT - APPEAL

For SSA Use Only - Do not write in this box.

Related SSN

Number Holder

If you are filling out this report for someone else, please provide information about him or her. When a question refers to "you", "your," it refers to the person who is applying for disability benefits.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

1.A. Name (First, Middle, Last, Suffix)

JESSIE WALKER III

1.B. Social Security Number

2104

1.C. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada) -8888

☐ Check this box if you do not have a phone number where we can leave a message

1.D. Alternate Phone Number, another number where we may reach you, if any

1.E. Email address (Optional)

gmail.com

SECTION 2 - CONTACTS

Give the name of someone (**other than your doctors**) we can contact who knows about your medical conditions, and can help you with your claim (e.g., friend or relative)

2.A. Name (First, Middle, Last)

2.B. Relationship to Disabled Person

DAUGHTER

2.C. Mailing Address (Street or PO Box), include apartment number or unit if applicable

City

State/Province

ZIP/Postal Code

Country (if not U.S.)

2.D. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

2.E. Can this person speak and understand English?

☒ Yes

☐ No

If no, what language does the contact person prefer?

2.F. Who is completing this form?

☒ The person who is applying for disability. (**Go to Section 3 - MEDICAL CONDITIONS**)

☐ The person listed in 2.A. (**Go to Section 3 - MEDICAL CONDITIONS**)

☐ Someone else (Please complete the information below)

2.G. Name (First, Middle, Last)

2.H. Relationship to Disabled Person

2.I. Mailing Address (Street or PO Box), include apartment number or unit if applicable

City

State/Province

ZIP/Postal Code

Country (if not U.S.)

2.J. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

SECTION 3 - MEDICAL CONDITIONS

3.A. Since you last told us about your medical conditions, has there been any CHANGE (for better or worse) in your previously described physical or mental conditions?

☒ Yes, approximate date change occurred: Mentally ~~Physically~~

If yes, please describe in detail:

Because I Hate white people.
They keep causing trouble so I got
A gun and I am going to shoot.

3.B. Since you last told us about your medical conditions, do you have any NEW physical or mental conditions?

☒ Yes, approximate date of new conditions: 03/01/2021

☐ No

If yes, please describe in detail:

PAIN DUE TO LEG I HAVE TO HAVE SURGERY ON 06/26/2021

year my SS Decision should have been base
on that because I been off of for over a
year for the same. Disiable.

If you need more space, use **SECTION 10 - Remarks** on the last page

SECTION 4 - MEDICAL TREATMENT

4.A. Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname.

☐ Yes

☒ No

If yes, please list the other names used:

4.B. Since you last told us about your medical treatment, have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled?

☒ Yes

☐ No (Go to **SECTION 6 - MEDICINES**)

4.C. What type(s) of condition(s) were you treated for, or will you be seen for?

☒ Physical

☒ Mental (including emotional or learning problems)

If you answered "Yes" to 4.B., please tell us who may have **NEW** medical records about any of your physical or mental conditions (including emotional or learning problems).

Use the following pages to provide information for up to three (3) providers. **Complete one page for each provider.** If you have more than three providers, list them in **SECTION 10 - REMARKS** on the last page.

Please include

- doctors' offices
- hospitals (including emergency room visits)
- clinics
- mental health center
- other health care facilities

Only list the providers you have seen since you last told us about your medical treatment.

SECTION 4 - MEDICAL TREATMENT (Continued)**Provider 1**

4.D. Name of facility or office HENRY FORD HEALTH SYSTEM	Name of health care provider who treated you
--	--

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number 313-916-2600	Patient ID# (if known)
------------------------------	------------------------

Address 2799 W GRAND BLVD

City DETROIT	State/Province MI	ZIP/Postal Code 48202	Country (if not U.S.)
-----------------	----------------------	--------------------------	-----------------------

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic, or Outpatient visits at this facility	Emergency Room Visits at this facility	Overnight Hospital Stays at this facility	
First visit 02/06/2021	Date 2/6/21	Date in 2/6/21	Date out 2/12/21
Last visit 03/12/2021	Date 3/22/21	Date in 3/22/21	Date out 3/30/21
Next scheduled appointment (if any)	Date 6/21/21	Date in	Date out
	<input type="checkbox"/> None	<input type="checkbox"/> None	

What new or updated medical conditions were treated or evaluated?

DIABETES MOTION SICKNESS

What new or updated treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

TESTING, AND MEDICATION

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☒ No (Go to the next page.)

KIND OF TEST	DATES OF TEST(S)	KIND OF TEST	DATES OF TEST(S)
<input type="checkbox"/> Biopsy (list body part)		<input type="checkbox"/> MRI/CT Scan (list body part)	
<input type="checkbox"/> Blood Test (not HIV)		<input type="checkbox"/> Speech/Language Test	
<input type="checkbox"/> Breathing test		<input type="checkbox"/> Treadmill (exercise test)	
<input type="checkbox"/> Cardiac Catheterization		<input type="checkbox"/> Vision Test	
<input type="checkbox"/> EEG (brain wave test)		<input checked="" type="checkbox"/> X-Ray (list body part)	6/21/21
<input type="checkbox"/> EKG (heart test)		<input type="checkbox"/> Other (please describe)	
<input type="checkbox"/> Hearing test			
<input type="checkbox"/> HIV Test			
<input type="checkbox"/> IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you do not have any more providers to describe, go to
SECTION 5 - OTHER MEDICAL INFORMATION on page 8.

SECTION 4 - MEDICAL TREATMENT (Continued)**Provider 2**

4.D. Name of facility or office MUSKEGON FAMILY CARE
Name of health care provider who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number 231-773-1317
Patient ID# (if known)

Address
 2201 S GETTY

City MUSKEGON
State/Province MI
ZIP/Postal Code 49444
Country (if not U.S.)

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic, or Outpatient visits at this facility	Emergency Room Visits at this facility	Overnight Hospital Stays at this facility	
First visit 02/16/2021	Date	Date in	Date out
Last visit 04/2021	Date	Date in	Date out
Next scheduled appointment (if any)	Date	Date in	Date out
	<input type="checkbox"/> None	<input type="checkbox"/> None	

What new or updated medical conditions were treated or evaluated?

PRIMARY CARE

What new or updated treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

MEDICATION

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	DATES OF TEST(S)	KIND OF TEST	DATES OF TEST(S)
<input type="checkbox"/> Biopsy (list body part)		<input type="checkbox"/> MRI/CT Scan (list body part)	
<input type="checkbox"/> Blood Test (not HIV)		<input type="checkbox"/> Speech/Language Test	
<input type="checkbox"/> Breathing test		<input type="checkbox"/> Treadmill (exercise test)	
<input type="checkbox"/> Cardiac Catheterization		<input type="checkbox"/> Vision Test	
<input type="checkbox"/> EEG (brain wave test)		<input type="checkbox"/> X-Ray (list body part)	
<input type="checkbox"/> EKG (heart test)			
<input type="checkbox"/> Hearing test		<input type="checkbox"/> Other (please describe)	
<input type="checkbox"/> HIV Test			
<input type="checkbox"/> IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you do not have any more providers to describe, go to SECTION 5 - OTHER MEDICAL INFORMATION on page 8.

SECTION 4 - MEDICAL TREATMENT (Continued)**Provider 3**

4.D. Name of facility or office	Name of health care provider who treated you DR CHRISTINA BUSTAMANTE
--	---

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number 586-772-8560	Patient ID# (if known)
------------------------------	------------------------

Address 29176 VAN DYKE AVE			
-------------------------------	--	--	--

City WARREN	State/Province MI	ZIP/Postal Code	Country (if not U.S.)
----------------	----------------------	-----------------	-----------------------

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic, or Outpatient visits at this facility	Emergency Room Visits at this facility	Overnight Hospital Stays at this facility	
First visit 02/11/2020	Date	Date in	Date out
Last visit 04/26/2021	Date	Date in	Date out
Next scheduled appointment (if any)	Date	Date in	Date out
	<input type="checkbox"/> None	<input type="checkbox"/> None	

What new or updated medical conditions were treated evaluated?

DIABETES

What new or updated treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

MEDICATION

I am going to shop people

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	DATES OF TEST(S)	KIND OF TEST	DATES OF TEST(S)
<input type="checkbox"/> Biopsy (list body part)		<input type="checkbox"/> MRI/CT Scan (list body part)	
<input type="checkbox"/> Blood Test (not HIV)		<input type="checkbox"/> Speech/Language Test	
<input type="checkbox"/> Breathing test		<input type="checkbox"/> Treadmill (exercise test)	
<input type="checkbox"/> Cardiac Catheterization		<input type="checkbox"/> Vision Test	
<input type="checkbox"/> EEG (brain wave test)		<input type="checkbox"/> X-Ray (list body part)	
<input type="checkbox"/> EKG (heart test)		<input type="checkbox"/> Other (please describe)	
<input type="checkbox"/> Hearing test			
<input type="checkbox"/> HIV Test			
<input type="checkbox"/> IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you have been treated by more providers, use SECTION 10 - REMARKS on the last page.

SECTION 5 - OTHER MEDICAL INFORMATION

5. Since you last told us about your other medical information, does anyone else have medical information about any of your **physical or mental** conditions (including emotional and learning problems) or are you scheduled to see anyone else?

This may include:

- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

☐ YES (Please complete the information below.)

☒ NO (Go to SECTION 6 - MEDICINES.)

Name of Organization

Claim or ID Number (if any)

Address

City

State/Province

ZIP/Postal Code

Country (if not U.S.)

Name of Contact Person

Phone Number

Date of First Contact

Date of Last Contact

Date of Next Contact (if any)

Reasons for Contacts

If you need to list more people or organizations, use SECTION 10 - REMARKS on the last page.

SECTION 6 - MEDICINES

6. Are you currently taking any medicines (prescription or non-prescription)?

☒ YES (Please complete the information below. You may need to look at your medicine containers.)

☐ NO (Go to SECTION 7 - ACTIVITIES.) *Going too shoot some white people*

NAME OF MEDICINE	IF PRESCRIBED, NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE
NOVOLIN 70/30	HENRY FORD DOCTOR	DIABETES	<i>All ways Mad</i>
ATONVASTATIN 10MG	CHRISTINA BUSTAMANTE	DIABETES	NONE
FORXIGA/PROZAC	MUSKEGON FAMILY CARE	DEPRESSION	
METFORMIN	CHRISTINA BUSTAMANTE	DIABETES	

If you need to list more medicines, use SECTION 10 - REMARKS on the last page.

SECTION 7 - ACTIVITIES

7. Since you last told us about your activities, has there been any **change** (for better or worse) in your previously described daily activities due to your physical or mental conditions? (Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.)

☒ Yes ☐ No

If yes, please describe in detail:

I DO NOT GO ANYWHERE BECAUSE OF MY MEMORY DUE TO MY DISABILITY I HAVE SHORT TERM MEMORY.

If you need more space, use **SECTION 10 - REMARKS** on the last page.

SECTION 8 - WORK AND EDUCATION

8.A. Since you last told us about your work, have you worked or has your work changed?

☐ Yes ☒ No

If yes, you will be asked to provide additional information.

8.B. Since you last told us about your education, have you completed or are you enrolled in any type of GED classes, specialized job training, trade school, vocational school or college classes?

☐ Yes ☒ No

If yes, what type?

Date(s) attended:

Degree(s) attained, if any:

Date of attainment (MM/YYYY):

If you need more space, use **SECTION 10 - REMARKS** on the last page.

SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

9. Since you last told us about your vocational rehabilitation, have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program?
- an individualized plan for employment with a vocational rehabilitation agency or any other organization?
- a Plan to Achieve Self-Support (PASS)?
- an individualized education program (IEP) through an educational institution (if a student age 18-21)?
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ Yes (Please complete the information below.)

☒ No (Go to **SECTION 10 - REMARKS**.)

Name of Organization or School

Name of Counselor, Instructor, or Job Coach

Phone Number

Address

City

State/Province

ZIP/Postal Code

Country (if not U.S.)

Date when you started participating in the plan or program:

If you need more space, use **SECTION 10 - REMARKS** on the last page.

Form **SSA-3441-BK** (01-2021) UF

Page 10 of 10

SECTION 10 - REMARKS

Use this space to provide any information you could not show in earlier sections of this form or additional information you feel we should know about. Please be sure to include the number of the question you are answering (For example, 3A, 4D, etc.).

Date Report Completed MM/DD/YYYY:

WALKER_0108